

VANEENS **

JUNE 2007

BY JAY BRADSHAW, EMT-P DIRECTOR MAINE EMS

Welcomes and Updates

Beginning this column again after being away for so long is like trying to catch up on the highlights of what has happened in the past 6+ months, and doing so in a single page.

Last Fall, after Medical Care Development published their last issue, we began the search to find someone who could take the Journal and build up its success, but perhaps with a new look. The result was that we were introduced to Scott and Melissa Arndt, the talent behind Slingshot Multimedia – and the result of that new partnership is in your hands today.

We are very pleased that the Journal of EMS is back and look forward to our new partnership with Slingshot Multimedia.

Welcome Commissioner Jordan

Earlier this year, former Public Safety Commissioner Michael Cantara was appointed to be a judge in the Maine District Court. When he left, Judge Cantara took with him the best wishes of our bureau and of the entire Department. We know he will serve the court well, and we hope to never see him again (in his new work setting).

The new Commissioner of Public Safety is Anne Jordan, of South Portland. Commissioner Jordan is no stranger to public safety as several members of her family have been, and continue to be, active members of Kennebunk Fire/Rescue. Prior to being appointed Commissioner, she was a partner with the law firm of Norman, Hanson, and deTroy, in Portland – and has served on many panels and advocacy groups. Within a short time of her being confirmed, Commissioner Jordan saw how things worked in a different way when the Patriot's Day storm hit our state. Along with the State Police, the Fire Marshal's Office and Maine EMS, the Commissioner was in the state Emergency Operations Center working closely



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with DPS and other agencies. Her first hand knowledge of York County came in particularly handy when that area was hard hit by this powerful storm.

More change came in April, when Scott Smith left his position as Education Coordinator to return to the nursing field. During his time at MEMS, Scott played a key role in the updated Paramedic Interfacility Transfer program, Ambulance Vehicle Operator Course, and began the process to work on updating several other curricula. We hope to fill his position soon – perhaps even by the time this issue is in the mail. More on that next time.

Legislative Update

The first regular session of the Legislature is always a busy one. That's the time when the biennial budgets are developed, reviewed, amended, and approved. That is also the time when most of the law changes are considered – and there are a couple that apply to EMS. The first such bill this session was about changes to the Emergency Medical Dispatch (EMD) section of the Law. Effective January 1, 2007, all call-takers in Public Safety Answering Points (PSAPs) were required to be certified in EMD. As a result of public hearings held last fall, several law changes were suggest, many of which were passed by the Legislature and signed into law.

MEMSRR

Significant progress has been made with the ongoing conversion to electronic run reporting in recent months. Ben Woodard, MEMS Data Coordinator has literally traveled the state to provide training and technical assistance to EMS services and hospitals about the Maine EMS Run Reporting System (MEMSRR).

This project has benefited from a Highway Safety grant to improve timely data reporting, data linkage, and public access. Through this grant, services are eligible to receive computer hardware and software at a greatly reduced price. But just like the man on TV says, "This offer is only good while supplies last, and certain conditions and restrictions apply."

If your service would like information on MEMSRR, please contact Ben Woodard at 207-626-3861 or by e-mail at: Ben.Woodard@maine.gov

It's been an interesting winter and spring in Maine, and while the effects will be felt for many months to come, especially in those counties hardest hit by the Patriot's Day Nor'easter, there is optimism now that the nicer weather is here, and the Red Sox are in first place.

Be safe, and please watch out for those of us on bicycles and motorcycles – we're baaaack! See you in a few months











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JULY 2007

Coronary Heart Disease and Heart Attack

You are called to the local bowling alley for a 53 year old man not feeling well. You are five minutes from the scene and once there you will be about 15 minutes from the local hospital. You are a basic EMT on a basic transporting service.

You arrive on scene, with your partner, you bring in a house kit, O_2 , and a stretcher. When you step inside you focus on your patient lying on the floor with his eyes closed. He is grey and diaphoretic. His grimace tells you

You find he has never had anything like this before... He appears to be moderately overweight, admits to 30 pack years of smoking and leading a sedentary yet stressful lifestyle with a family history of heart disease.

he is uncomfortable. There are a few people with him one with a wet cloth on his head another kneeling beside him looking a bit distraught. There is nothing unusual or unsafe about the scene. As you approach your patient one of the bystanders identifies herself as a nurse and tells you how the patient got diaphoretic and queasy. He lowered himself to the ground and although he denies chest pain he did clutch his chest.

You approach your patient who remains eyes closed and struggles to answer you as if speaking is painful. You notice his clothes are drenched in perspiration and his color is a shade of grey that doesn't seem to represent adequate perfusion. You establish he has an adequate airway and is breathing normally. He responds appropriately to your questions and appears conscious, alert and oriented, although you notice he seems uncomfortable trying to speak. He expresses to you this came on suddenly and is not really pain but heaviness and discomfort in his chest neck and back. You continue questioning him and you find the episode started about 10 minutes ago and he was unable to do anything except lie down. He rates his "discomfort" an 8, 1-10. You find he has never had anything like this before, he hasn't seen a doctor in

over 30 years, takes no medications and has no allergies. He appears to be moderately overweight, admits to 30 pack years of smoking and leading a sedentary yet stressful lifestyle with a family history of heart disease. He lets you know he feels nauseous. Your partner is applying a non-rebreather and is getting vital signs. You ask your partner to call for ALS back up. You continue to ask questions covering your OPQRST and SAMPLE with no further significant findings. Your partner tells you he has a B/P of 148/96, a pulse rate of 122, and he is breathing at a rate of 20 times a minute non-labored with clear and equal lung sounds. You ask the check pain checklist questions per MEMS protocol and find the patient takes no erectile dysfunction medications then proceeds by administering 4 chewable aspirin for a total 364mg while you transfer the patient to your stretcher and head for the ambulance. You reassess vitals; they remain the same so you contact medical control, apprise him of your patient and are given orders for 0.4 mg sublingual nitroglycerin or one spray. You administer and reassess with only a small drop in B/P to 136/90. Your patient remains uncomfortable. ALS meets you enroute. The paramedic who responds listens to your report and talks to the patient. She asks you for a new set of vitals and administers

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His grimace tells you he is uncomfortable. ... He lowered himself to the ground and although he denies chest pain he did clutch his chest.



You prepare an intravenous set up and the medic cannulates and runs normal saline at a "to keep open" rate. You contine reassessing your patient and the medic contacts medical control.

another nitro. She also obtains an EKG showing a sinus tachycardia with profound ST elevations. She attaches a 12 lead EKG and finds ST elevations in lead II, III, and AVF which is indicative of an inferior MI with potential blockage of the right or left coronary artery[1]. You prepare an intravenous set up and the medic cannulates and runs normal saline at a "to keep open" rate. You continue reassessing your patient and the medic contacts medical control. She is advised to continue with the nitro as long as the B/P remains stable and to administer 25mg of Fentanyl. Following this your patient finds some relief. He now states his discomfort is a 4 on a 1-10 scale.

You arrive at the hospital where you and the medic report to the patient's nurse and ED physician. The patient is tested and treated aggressively. He is given tPA. Tissue plasminogen activator (tPA) is a thrombolytic agent (clot-busting drug) approved for use in certain patients having a heart attack or stroke. The drug can dissolve blood clots, which cause most heart attacks and strokes. Studies have shown that tPA and other clot-dissolving agents can reduce the amount of damage to the heart muscle and save lives. However, to be effective, they must be given within a few hours after symptoms begin. Administering tPA or other clot-dissolving agents is complex and is done through an intravenous (IV) line in the arm by hospital personnel.[2]

The patient was then transferred to another hospital with a coronary care unit where he underwent percutaneous coronary intervention (PCI), including balloon dilation and stent placement. PCI encompasses a variety of procedures used to treat patients with diseased arteries of the heart, for example, chest pain caused by a build-up of fats, cholesterol, and other substances from the blood (referred to as plaque) that can reduce blood flow to a near trickle, or a heart attack caused by a large blood clot that completely blocks the artery.

Typically, PCI is performed by threading a slender balloon-tipped tube - a catheter - from an artery in the groin to a trouble spot in an artery of the heart (this is referred to as percutaneous transluminal coronary angioplasty - also known as PTCA, coronary artery balloon dilation or balloon angioplasty). The balloon is then inflated, compressing the plaque and dilating (widening) the narrowed coronary artery so that blood can flow more easily. This is often accompanied by inserting an expandable metal stent. Stents are wire mesh tubes used to prop open arteries after PTCA.[3]

The patient was educated on healthy heart living through an inpatient and outpatient program at the hospital and several years later has negative quality of life changes from the incident. He now runs five miles a day 5 days a week, is physically fit, eats well balanced healthy meals, is a non-smoker but does take cholesterol and hypertensive medications daily. He sees his physician regularly and attempts to modify all risk factors for heart disease with in his control.

Extensive clinical and statistical studies have identified several factors that increase the risk of coronary heart disease and heart attack. Major risk factors are those that research has shown significantly increase the risk of heart and blood vessel (cardiovascular) disease. Other factors are associated with increased risk of cardiovascular disease, but their significance and prevalence haven't yet been precisely determined. They're called contributing risk factors. The American Heart Association has identified several risk factors. Some of them can be modified, treated or controlled, and some can't. The more risk factors you have, the greater your chance of developing coronary heart disease. Also, the greater the level of each risk factor, the greater the risk. For example, a person with a total cholesterol of 300 mg/dL has a greater risk than someone with a total cholesterol of 245 mg/dL, Even though everyone with a total cholesterol greater than 240 is considered high-risk. According to the American Heart Association The major risk factors which can be modified, treated, or controlled by changing your lifestyle or taking medicine are Tobacco, High Blood Cholesterol, High Blood Pressure, Physical Inactivity, Obesity and Overweight Diabetes Mellitus, alcohol, and stress. The major risk factors for heart disease which cannot be changed are Increasing Age, Male Sex (Gender), and Heredity (Including Race).[4]

American Heart Association lists the following facts regarding risk factors

Increasing age: Over 83 percent of people who die of coronary heart disease are 65 or older. At older ages, women who have heart attacks are more likely than men are to die from them within a few weeks.

Male sex (gender): Men have a greater risk of heart attack than women do, and they have attacks earlier in life. Even after menopause, when women's death rate from heart disease increases, it's not as great as men's.

Heredity (including Race): Children of parents with heart disease are more likely to develop it themselves. African Americans have more severe high blood pressure than Caucasians and a higher risk of heart disease. Heart disease risk is also higher among Mexican Americans, American Indians, native Hawaiians and some Asian Americans. This is partly due to higher rates of obesity and diabetes. Most people with a strong family history of heart disease have one or more other risk factors. Just as you can't control your age, sex and race, you can't control your family history. Therefore, it's even more important to treat and control any other risk factors you have.

Tobacco smoke: Smokers' risk of developing coronary heart disease is 2 to 4 times that of nonsmokers. Cigarette smoking is a powerful independent risk factor for sudden cardiac death in patients with coronary heart disease; smokers have about twice the risk of nonsmokers. Cigarette smoking also acts with other risk factors to greatly increase the risk for coronary heart disease. People who smoke cigars or pipes seem to have a higher risk of death from coronary heart disease (and possibly stroke) but their risk isn't as great as cigarette smokers'. Exposure to other people's smoke increases the risk of heart disease even for nonsmokers.

High blood cholesterol: As blood cholesterol rises, so does risk of coronary heart disease. When other risk factors (such as high blood pressure and tobacco smoke) are present, this risk increases even more. A person's cholesterol level is also affected by age, sex, heredity and diet.

High blood pressure: High blood pressure increases the heart's workload, causing the heart to thicken and become stiffer. It also increases your risk of stroke, heart attack, kidney failure and congestive heart failure. When high blood pressure exists with obesity, smoking, high blood choles-

terol levels or diabetes, the risk of heart attack or stroke increases several times.

Physical inactivity: An inactive lifestyle is a risk factor for coronary heart disease. Regular, moderate-to-vigorous physical activity helps prevent heart and blood vessel disease. The more vigorous the activity, the greater your benefits. However, even moderate-intensity activities help if done regularly and long term. Exercise can help control blood cholesterol, diabetes and obesity, as well as help lower blood pressure in some people.

Obesity and overweight: People who have excess body fat - especially if a lot of it is at the waist - are more likely to develop heart disease and stroke even if they have no other risk factors. Excess weight increases the heart's work. It also raises blood pressure and blood cholesterol and triglyceride levels, and lowers HDL ("good") cholesterol levels. It can also make diabetes more likely to develop. Many obese and overweight people may have difficulty losing weight. But by losing even as few as 10 pounds, you can lower your heart disease risk.

Diabetes mellitus: Diabetes seriously increases your risk of developing cardiovascular disease. Even when glucose levels are under control, diabetes increases the risk of heart disease and stroke, but the risks are even greater if blood sugar is not well controlled. From two-thirds to three-quarters of people with diabetes die of some form of heart or blood vessel disease. If you have diabetes, it's extremely important to work with your healthcare provider to manage it and control any other risk factors you

Stress: Individual response to stress may be a contributing factor. Some scientists have noted a relationship between coronary heart disease risk and stress in a person's life, their health behaviors and socioeconomic status. These factors may affect established risk factors. For example, people under stress may overeat, start smoking or smoke more than they otherwise would.

Alcohol: drinking too much alcohol can raise blood pressure, cause heart failure and lead to stroke. It can contribute to high triglycerides, cancer and other diseases, and produce irregular heartbeats. It contributes to obesity, alcoholism, suicide and accidents. The risk of heart disease in people who drink moderate amounts of alcohol (an average of one drink for women or two drinks for men per day) is lower than in nondrinkers. One drink is defined as 1-1/2 fluid ounces (fl oz) of 80-proof spirits (such as bourbon, Scotch, vodka, gin, etc.), 1 fl oz of 100-proof spirits, 4 fl oz of wine or 12 fl oz of beer. It's not recommended that nondrinkers start using alcohol or that drinkers increase the amount they drink.[5]

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CEH Corner

Once you have read the article, Coronary Heart Disease and Heart Attack, you can correctly complete the following set of questions and receive one hour of MEMS-approved CEH credit, 0.5 Cat 2 (BLS Topics), and 0.5 Cat 4 (ALS Topics). You will need to tear out this questionnaire and mail it to JoMEMS, c/o Kelly Roderick, 141 Fairfield Street, Oakland, ME 04963 or email the answers to all of the following questions to kr8264@gmail.com. Please return absolutely no later than July 27, 2007.

1. Per protocol which drugs and their dosages can be given to a patient complaining about cardiac chest pain?					
2. What risk factors for heart disease can be modified?					
3. What kind of questions should be asked of a cardiac chest pain patient?					

- [1] http://www.ems-safety.com/12%20lead%20ekg.htm
- [2] http://www.americanheart.org/presenter.jhtml?identifier=4751
- [3] http://www.americanheart.org/presenter.jhtml?identifier=4454
- [4] http://www.americanheart.org/presenter.jhtml?identifier=500
- [5] http://www.americanheart.org/presenter.jhtml?identifier=500



EMS Week Marks Maine EMS Memorial Plan Unveiling and Campaign Kick-Off

After nearly three years of planning, legislative process, and negotiations with State government agencies, the Maine EMS Memorial Project is entering its final phase: fundraising and construction. The design for the Memorial was unveiled at the May 22nd Maine EMS Week awards ceremony at the State House. The fundraising campaign to support the building and maintenance of the Memorial was also announced.

The Memorial Project is intended to produce a permanent tribute to those who are the foundation of Maine's EMS system. Legislation was passed in 2005 to create a legislative study committee to establish the design, location, content and cost of the memorial. That committee reported back to the Legislature in 2006 with its recommendations for a memorial located with the police and fire memorials in Augusta.

Several months were then spent in negotiations to establish whether the memorial would be added to that site or whether it would be add-





ed to a site on the grounds of AMHI where a new memorial park is planned. When moving the fire and police memorials to the new memorial park proved not feasible, it was determined that the EMS memorial would be built with the fire and police memorials near the State House.

More negotiations ensued in an attempt to eliminate a driveway between the police and fire memorials to create a more unified public safety memorial park. This effort recently failed when the State agency in charge determined the driveway to remain.

The Memorial Project committee is led by the project's originator, former state EMS director, Kevin McGinnis; Winthrop EMT Cynthia Thompson; North-Star EMT-I Carla DeGraw; and regional coordinator Rick Petrie. In its legislative phase, the committee also included Representatives John Tuttle and Terrence McKenney, both EMTs. For more information on helping with the project, contact Kevin McGinnis at k.mcginnis@adelphia.net. To help with fundraising, please contact Rick Petrie at 207-877-0936 or 207-974-4879.

The Memorial Project is intended to produce a permanent tribute to those who are the foundation of Maine's EMS system.

Public Safety Commissioner Anne H. Jordan standing next to the architect's drawing of the EMS Memorial. (photo by Nancy P. McGinnis)

Call to Action BY DAN BATSIE NORTHEAST MAINE EMS

Nearly two years ago Maine EMS undertook a sweeping revision of the state's approach to airway management. Those changes were in part driven by a significant amount of nationwide literature that demonstrated very serious concerns with regard to prehospital endotracheal intubation. The 2005 protocol change began a team-based approach to address these challenges. Each component of our system worked together to improve. MEMS leadership expanded our protocols to include new devices and an organized airway algorithm; our educators developed new training to improve provider skill and judgment; and at no small cost, our services have initiated that training. The final and most important component of this team based approach is a quality assurance review and unfortunately, we the providers are not holding up our end of the bargain.

The nationwide concerns with regard to prehospital intubation have not gone away. In fact, if anything, they have intensified. The five most significant airway studies have demonstrated prehospital intubation success rates to hover dismally around 57% to 82%¹. Armed with this information, many well known voices in EMS, including paramedic text book author Brian Bledsoe, have guestioned why we continue to include intubation in an EMS intermediate and paramedic scope of practice. If you feel that this question will never be raised in Maine you are absolutely wrong. Look no further than our closest neighbor, New Hampshire and see a state that has removed intubation from its intermediate prehospital formulary.

Many of you will challenge the nationwide data and say, "those studies had significant limitations and cannot be applied here" and in many cases you will be right. Unfortunately, if we look at QA completion rates thus far, many of you will also be the provider who neglects to fill out a QA form after managing an airway, or the provider who fills out only half the page. It is absolutely essential to understand that when a provider in Maine neglects to fully complete an airway QA form he or she misses an opportunity to address these limitations.

With regard to airway management, the Maine EMS run sheet is a "yes or no question." Until we can fully implement electronic run reporting, there is no opportunity to demonstrate the "why's, how's and other circumstances" that make prehospital airway management so different than any other environment. The MEMS airway QA form is that opportunity. Completion of these forms will allow the review to include special circumstances and point out why studies from other states cannot be applied here in Maine. More importantly though, complete forms allow a larger statewide review to examine the efficacy of the steps we have undertaken thus far. Completion provides the possibility for EMS providers to demonstrate that with proactive steps we can improve and do deserve the skill of endotracheal intubation to be left within our scope.

As a system we have addressed a problem. As a provider, are you doing your part?

¹See Gausche, M. JAMA 2/2000; 283:6, Wang, H. Annals, 11/2004; 44:5., Burton, J. Prehosp. Em. Care. 11/2002; 2003;7. Ochs, Mel, Davis, et al. J. of Trauma. 3/2003; 54(3):444-453, , Jemmett, M, et al. Acad. Em. Med. 9/2003; 10:9

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Witness to the Dead

By Erik N. Steele, D.O.

More of the dead came into my home again last week, because more helicopters had gone down, more bombs had gone off, and more of our soldiers had gone home flag-draped to taps and headstones. When they come I feel it is my duty to watch them, to acknowledge their sacrifice, and accept my share of the pain every one of us should feel when one of them dies.

They came to me last week, as they always do, in the "Honor Roll" of American war dead on the PBS "News Hour with Jim Lehrer". The program shows the photographs, names, ages, ranks, and hometowns of American service men and women killed in Iraq and Afghanistan as the information becomes available. It is the ultimate in reality TV, and no seconds on television last any longer than these.

In some ways the worst of the Honor Roll is the first of it, when Lehrer says how many dead we will see that night. Each time I will that the Honor Roll be short; "Two, just two," I ask, but Lehrer never listens to me. When he said last Friday, "Here, in silence, are fourteen more," it was almost too much to bear to watch.

Picture by picture, I look at every one, at their faces and their eyes, and think about each. Occasionally the picture is of a woman killed in combat, infrequently enough to still be a surprise but frequently enough that it is no longer a shock. One was the first-ever African-American woman to be the top cadet at West Point; she was a star at 21 and dead at 22.

When the eighteen-year-olds make the Honor Roll I wonder how kids who are so young they probably still laugh at fart jokes and love skateboarding are old enough to be fighting for us. As a parent it is difficult for me to watch the Honor Roll without acknowledging what a collective failure it represents for a generation of parents to send their children off to war.

If I was the parent of a child in combat and saw two uniformed military members walking toward the front door of my home I think I would run out the back door in the desperate hope that as long as they could not tell me of his death he could not be dead, and run forever if that would make it so.

When I watch I also think of the physicians and nurses in the military's Baghdad emergency department who tried to save the dead when they were still just dying, when there was still perhaps a thin pulse and a thin hope of keeping the wounded off the Honor Roll. In my heart I can sense the crushing weight of loss a trauma team feels each time they lose a tug-of-war with the Grim Reaper. I can hear the silence that suddenly descends over a busy ER when the lead doc says "That's it, everyone, time to stop. Time of death is" I know the urge some of them have to sink to the bloody floor and cry like babies, partly for this dead soldier, partly for the next one, partly for themselves because having seen what they have seen they will never be the same.

More than three thousand men and women have died since our wars started in Afghanistan and Iraq, and that many departed souls leave a lot of holes behind. As I watch the dead go by I think of their families, too. There are lovers who will not be caressed and babies not made, favorite baseball gloves missing the confident hand that flicked them easily and accurately in front of bouncing grounders, and favorite meals that will never be made again without the spice of sadness.

There are clothes that will slowly lose the familiar smell of the forever missing, but until then will provide soft comfort when held close and filled by memory with the warm form of a lost one.

Every death means calls bearing the news to family members. I have been on both ends of such calls, and as I watch the Honor Roll I think of that crystalline moment just before one heartbroken family member has to speak the shattering words, and another family member has to hear them. Life as they knew it fragments like glass in a framed photograph that someone dropped; it gives a whole new meaning to the term "breaking news."

Next week there will be more such calls, and another Honor Roll, and I will be there.

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EMS News Shorts

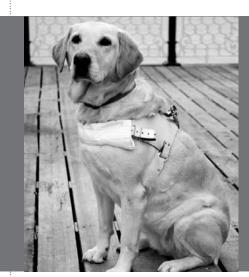
Laboratory Testing Waivers

Under Federal Law, Laboratories that conduct blood testing need to be licensed. Technically, this would include Maine EMS services that do Glucometer testing, regardless of service license/permit level or whether your service is a First Responder or Transporting Service. The good news is that EMS services have been authorized to request a waiver from the license; the bad news is that there is a \$150 fee that must be included with each waiver application, and the service must fill out a new waiver application every 2 years. Services performing Glucometer testing that don't have a current CLIA waiver are performing unlicensed testing and are subject to fines or even loss of Medicare/Medicaid funding. Maine EMS attempted to obtain one waiver for all EMS services in 1992, but this request was denied by the Federal Government. To obtain the waiver materials, contact Margaret Naas, Division of Licensing and Certification, CLIA Program, 41 Anthony Ave., 11 State House Station, Augusta, ME, 04333-0011, Phone 287-9339; or download the materials at: www.cms.hhs.gov/ cmsforms/downloads/cms116.pdf. Once you send in the application, an invoice is sent to your organization. In addition, they will send you renewal notices at 6-, 4-, and 2-months prior to the expiration date.



Emancipated Minors

Recently, a question was raised about pregnant minors and emancipation, particularly as it relates to refusal of care or transport. A little research shows that Emancipation is an established legal process and is not automatically granted just because the minor is pregnant. Minors who have gone through the process and been legally emancipated are supposed to carry the paperwork with them proving that they are legally entitled to make their own decisions. Service should ask to see the paperwork when faced with this situation. If the minor cannot produce the required proof, then the provider should err on the side of treating the patient as a minor.



Service Animals

Another question that has come up is the transport of service animals by EMS services when their owner is being transported. Basically, service animals are allowed under the law to accompany their owners anywhere, as long as they are under control. Service animals can be refused access or removed if their behavior is dangerous or if the animal refuses to allow access to the patient. This should be rare, because most service dogs are trained to ride in an ambulance. Service animals should be easily identifiable by some marking (collar, bandana, vest, etc.) that identifies them as such. Assistance Canine Education & Support (ACES) is available to provide continuing education training to EMS services. You can contact them by going to their website, http://www. acesinfo.org or by contacting Judi Bayly at judibayly@ hotmail.com.

Moral Support

Our new neighbor and her husband had recently purchased one of the old houses on Matinicus Island, intending to join the ranks of the "year-round part-timers." On this November day, they rode the ferry to the island, accompanied by a handful of friends looking forward to a few days visit in a place reputed to be a little bit wild, and loved by some for its isolation.

As the population shrinks in the fall, the likelihood of these calls also shrinks. We are nothing if not grateful for the lack of critical calls. Somehow, though, I was feeling a bit confused about my role.

Matinicus gets only one or two state ferry trips, out of Rockland, in November, and the seas are notoriously rough. I've been on more than one trip myself where the lyrics to "the Wreck of the Edmund Fitzgerald" become stuck in my mind, while my stomach feels like a rotten onion and three bricks in a punching bag. The ferry vessel offers little for comforts; you might choose to ride in the narrow passenger cabin with its rigid metal seats, relaxing with the high-pitched whine from the engines, the vaguely diesely smell, and the close proximity of other travelers with their crunching Cheetos, their restless dogs, their snoring or their chatter. The other choice is the wet vehicle deck, where you shoehorn yourself between lumberyard trucks and overloaded pickups to stand where you can see (if it isn't too foggy,) or to be sick over the side, or to get some fresh air (but a cold saltwater bath is often the price of that fresh air.) Some people prefer to sit in their own vehicle, if they've brought one. Sometimes, though, that results in a "talker" wedging themselves in by your rolled-down window and monopolizing the two-hours-plus of the trip, and making of you a captive audience.

Anyway, after our new homeowners unloaded everything they'd brought for the island house, he drove their truck back onto the ferry, to take it back to the mainland (the alternative being to have the truck marooned on the island for several weeks.) He would hop the mail plane back out tomorrow, or some time soon. Meanwhile, she and her friends would enjoy a few days off, walk deserted beaches, putter about in the rambling old house.

It had been a rough trip, though, and she'd evidently been quite seasick. She went to lay down for a while.

Meanwhile, the Annual Seminar, sponsored by the Mid-Coast EMS Council and held at the Samoset Resort in Rockport, was kicking into full swing. Hundreds of EMTs, paramedics, firefighters and nurses were assembled to take classes, socialize, and especially for the more isolated, small town responders, to experience some of the peer support and team spirit that isn't always part of their work situation. I say "their," but I mean "our." One EMT who attended and turned out to be badly in need of a little dose of EMS community cheerleading was Yours Truly.

The previous summer had resulted in exactly three run reports from Service #924 Matinicus Island Rescue...one dog bite, one motorbike wipeout with painful but basically superficial injuries, and the poor guy who'd managed (at 4AM while aboard the boat) to clobber himself upside the head with a monkey wrench. None of them had required emergency transport (the "possible broken jaw" and the "multiple lacerations" were transported by the patient's family or employer. The dog bite was not serious at all, and was treated here, but I do run sheets on all dog bites, just in case we have a repeat offender dog around and need the evidence.) Our extrication stuff, c-collars, the backboard, the AED, sit in the

Hundreds of EMTs, paramedics, firefighters and nurses were assembled to take classes, socialize, and especially for the more isolated, small town responders, to experience some of the peer support and team spirit that isn't always part of their work situation.





I was, in fact, beginning to feel like an EMS fraud. I'd been an EMT for twelve years and hadn't responded to many emergencies.

Stayed up all night with people while they dealt with their problems, yes.

Watched people suffer, worry, even flatline in the hospital, ... yes...

Provided real medical interventions, no.



first aid shed, unused. We haven't had to call LifeFlight or the Coast Guard this year, and our biggest fear, the selfdestructive behaviors of some of our rowdier neighbors, had thankfully not resulted in any crashes, shootings, or overdoses. As the population shrinks in the fall, the likelihood of these calls also shrinks. We are nothing if not grateful for the lack of critical calls. Somehow, though, I was feeling a bit confused about my role.

This year I had responded, time after time, to the woman who wanted her elderly husband "looked at" because several days prior he'd had a nasty cold and couldn't breathe right (but now was much better.) I asked, each and every time, why they didn't call when he was having breathing problems, and got the old "we didn't want to bother you" or some similar reply. "Has he been using his oxygen?" I'd ask. "Well, you know him...." I guess not.

I responded when the crowd of panicked summer people rushed like a freight train into my kitchen in August, screaming that a little child had been run over by a truck. Somebody ran toward my house with a small neighbor boy. He was crying, mostly upset that he would be in trouble for not looking where he was going before pulling out into the dirt road on his four-wheeler. His vitals were normal, he had no pain or tenderness, and once he was calmed down enough to explain what happened, it became clear that the real "patient" was probably the adult who nearly hit him, whose door or mirror bumped the boy's ATV handlebars, and who was, inevitably, extremely shook up. The boy's father collected him, everybody left, and I was left standing in my driveway wondering whether that had been an EMS call or not.

I had responded to one human bite, the result of a brawl on the wharf. All I could do was bring a bottle of Betadine to the man's kitchen table and teach about the signs of infection. I responded to a dislocated patella, but the teenagers nearby who'd had some first aid training had handled it well. The patient reduced it herself, and all we could do was get her inside, ice and wrap her knee, lend her some crutches, help contact her family, and calm her down while she panicked that her coach wouldn't let her play field hockey next year if he found out that this kept happening. I responded to numerous unexplained rashes, all sorts of mysterious uncomfortable afflictions, none serious, but I had to look up scabies for people in medical books to prove to them that no, they didn't have it. I recommended a lot of washing, I handed out various over-the-counter and herbal ointments with varying degrees of effectiveness, but mostly I reassured people that, 1. they didn't appear to be about to die of anaphylaxis, 2. the island is not covered with poison ivy and 3. little Suzie next door is not carrying some sort of contagious plague.

I responded to a small but nasty burn, (or, more accurately, the burn was brought to my kitchen door,) but only after several others had responded to it first, and nothing would do but the whole island had to be in on it. The patient had used gasoline to start a fire in the wood stove, and somehow had managed not to burn the place down. Amazingly, no significant injury was sustained, but the politics and gossip around that case became a three-ring circus. I feared that I was being used as leverage in a neighborhood squabble... "I told him he had to go see you," said the guy's employer. "I told him those other people he went to weren't qualified. Isn't that right? They ain't really qualified, are they?" That put me in an awkward position. The patient was getting along fine, and it wouldn't have taken a brain surgeon to recommend appropriate treatment for this burn (mostly, stop messing with it, leave it alone,) but after they all got done talking at and about each other, I sort of wished I hadn't been around that week.

There were enough times when I wasn't around. I didn't respond to the woman who fell on her deck while moving a heavy load and injured her back. Those who did were unable to convince her that she might require immobilization, so she was walked to the airplane and flown, sitting, to the mainland. She wouldn't have it any other way. I doubt that I'd have had any better luck convincing her to allow a "real EMS response," but I couldn't help but wonder, as she went through her back surgery, and her pain...for a long time. Would it have been any different had I been there? Probably not.

One reason why I wasn't home, able to respond to EMS calls, was because I was on the mainland with relatives who had their own health issues. I got my first ambulance ride in years in October, when the patient was my grandmother, and the paramedic was the guy who'd taught my initial EMT class back in 1994 (that would be Luke.) Was that an EMS call? No. I was the one who recognized the stroke for what it was...still, so might have anybody. I just happened to be there.

I was, in fact, beginning to feel like an EMS fraud. I'd been an EMT for twelve years and hadn't responded to many emergencies. Stayed up all night with people while they dealt with their problems, yes. Watched people suffer, worry, even flatline in the hospital, because I am, say the relatives, "the one who can deal with it," yes. Helped the cops load the body, yes. Provided real medical interventions, no.

As required, I carry the 911 pager all day, and put it down beside my bed every night, and hope more than anything that it does not go off. Once or twice a year, when it does, it scares the hell out of me. Usually it's the County looking for somebody to ask about who we use for tow-truck service out here, or some other such nonsense. I am not used to this. I do not use a pager for any other business, so I assume that the ring can mean only one thing...the unexploded ordnance on Seal Island has gone off and ripped apart some unsuspecting kayaker, or a yachtload of tourists has just discovered that they're all deathly allergic to lobster (and I've only got two epi-pens,) or the annual carpenter-and-chopsaw incident is the real thing this time, and there's an amputated hand in that guy's balled-up T-shirt. Or, that my first cardiac arrest call is about to present itself.

Meanwhile, I take more blood pressures for folks at their (or their physician's) request, peek into more baby ears, look things up for people in the Merck book, and hand out the loaner crutches. I'm glad they think I'm so useful around here.

At the EMS seminar, I go to classes with people who stare death in the face every day (if they'll pardon the pitifully overused expression.) I practice skills with people who save lives on a regular basis, and who know their way around emergency departments like I know my sock drawer. I was feeling a little bit undeserving of the title "EMT," with all the boosterism that comes with it at the Seminar, when I called home on that Friday to check in with my husband.

Remember the new neighbor, who'd had the bad ferry ride out? While I had been practicing with a bag-valve-mask on a set of deer lungs from an animal that had been hit over by Augusta somewhere and salvaged for this purpose by a forward-thinking

responder, my neighbor had been struggling to breathe. Evidently she had aspirated some stomach acid while seasick on the ferry, and her discomfort turned into a nasty case of full-blown chemical-burn pneumonia. She had not called for help until things were quite bad, though, and when the semi-retired nurse and the electrician responded with the oxygen and the ride to the airplane, she was, between the pain, the fear, and the hypoxia, in very rough shape. Somebody later commented that they weren't at all sure she'd make it as far as the mainland.

The island EMTs were at the seminar. "What could we have done any different?" someone asked. Well, we could have "bagged" her; that might have helped, during the transport. We could have gone with her, so a relative wouldn't have to be the one to deal with the mainland ambulance. We might have got the oxygen to her possibly five minutes sooner, because we wouldn't have had to look for it. "At least," everybody said, "the weather was decent so the plane could fly." In fact, the air transport was very fast and efficient, and our thanks go to Rod and Kevin and everybody who was involved in that. The pilot was already on the island, so it couldn't have been any quicker.

My conscience was beating me up over this one. This was the only critical call in many months, and we weren't around to help.

Readers will be asking themselves, "How can that be? An ambulance service is required to offer 24-7 coverage! Why didn't one of the EMTs stay home?" Yes, you're right. However, a few years ago, when our roster was down to one licensed member, that policy sort of disintegrated into "We'll do the best we can, and it'll have to be better than nothing." Most of the time, one of us is here, but there are only two of us year-round, and we count on the Seminar at the Samoset to fulfill our continuing education needs, because there sure isn't going to be a lot of training offered at the local fire station! (That's supposed to be a joke...)

With a call volume as low as ours, it is easy to think "nobody really needs us anyway. They all just want somebody to hold their hand."

That kind of thinking can get you down. It might be a slightly saner attitude than to be a walking, talking ego trip, a self-aggrandizing boor who thinks of him- or herself as indispensable, as Doctor Kildare and the fount of all medical knowledge, but still, to feel borderline useless doesn't help. I was beginning to get annoyed with the "frequent flyer" neighbors and their two-armed blood-pressure demands, with the bored shut-in who wants her doorstep shoveled, with the drunks who get hurt and then laugh in my face when I try to help, and with the mommies who think every splinter in their child's toe requires a trip to the hospital. I have a neighbor who feels she should call to inform me each time her doctor adjusts her medi-

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It is not a "shell-shock" sort of burnout, but an insidious feeling of inadequacy and nervousness. It arises from the potential for critical cases where no transport is possible, the laying awake nights in a storm, hoping nobody's out there driving drunk, and knowing perfectly well that they are.

cation. I've been tempted to reply, "I don't give a damn, why are you calling me?" I don't mean it.

At the Seminar, I had signed up for the CISM class. There were combat veterans, people who worked in criminal justice, "real" EMTs with many years of experience. Mostly, we told stories. I began to harangue about the above-mentioned thankless tasks. The instructor told me I was getting "burned out" and to cut myself some slack, allow myself some help. "Burned out? No way! That's for people who do REAL EMS," I told myself. "How can anybody experience burnout when they hardly ever get any calls? I should just quit anyway, because I can't seem to be any use to anybody when there is a real call..."

It is not a "shell-shock" sort of burnout, but an insidious feeling of inadequacy and nervousness. It is resentment of the pager. It is the certainty that a serious call will ring in that one time you allow yourself a second glass of wine. It is because even when calls are infrequent, the anxiety is still there, because there is no designation of "off duty." It comes from the sense of responsibility that doesn't end with turning the patient over to a higher level of care...because the patient won't go. It comes from the community health nurse role, for which we weren't really trained, but learned on the job. It arises from the potential for critical cases where no transport is possible, the laying awake nights in a storm, hoping nobody's out there driving drunk, and knowing perfectly well that they are. It is worsened by the fact that most of my patients come to me specifically because they DON'T want to go to the doctor, and have no intention of allowing transport. That is just a tiny bit stressful. It comes, finally, from the guilt each time somebody comes to my house for help, and finds that I am not there.

I spent the three days of the Seminar feeling perfectly awful, worrying about the woman with the chemical pneumonia, feeling like an imposter, wasting all that donated money taking "rescue" classes while she suffered in the hospital. Luckily, I am an EMT, and with that comes a support system. Allow me to publicly offer thanks to all the supportive folks...many of whom didn't know that they were saying what I needed to hear, at just the right time. All sorts of people were very helpful that weekend. Had I not had more experienced responders around me to keep saying sensible and appropriate things, I am sure I'd have felt bad a lot longer. I'm not much of a "joiner;" people who live on islands typically aren't. I don't usually feel like I'm part of a team. I don't have a truck plastered with lights and stickers and paraphernalia announcing my job as a rescuer. In fact, I used to make light of that stuff...all the psychological candy, the ego boost, the sense of strength and togetherness that is often the only benefit or pay for a volunteer job (sometimes performed in a dangerous setting, at an inconvenient time, in mud and ice, in fear and heartache, or in the middle of dinner.) I do not make light of it any more.

I went to the vendor's area and bought a ridiculously expensive sweatshirt that said "Emergency Medical Technician." I felt a little embarrassed to do so; "Hmph. Real EMTs would laugh at my kind of calls." No, they wouldn't, and they didn't, and I am grateful for what Robin and Pete and various others said that weekend, (and that includes guest speaker Steve Berry.) The camaraderie at the Saturday banquet was therapeutic...more so than might make sense to someone who hasn't felt it. After a while, I realized that the silly sweatshirt was a good idea too. None of us is alone in this job.

By the way, the woman with pneumonia spent several weeks in Maine Medical but is OK now, and so am I.

Delta Ambulance: Compassion - Leadership- Excellence



Delta Ambulance Delivers Annual Employee Recognition

Delta Ambulance, with bases in Waterville and Augusta, celebrated employee achievements for 2006 in April. Honorees were recognized by Tim Beals, Delta's Executive Director, Mike Roy, Delta Board President, and Dr. Steve Diaz, MD, Delta's Medical Director.

Clinical Standards and Practice Excellence Award

Steve Winn, Ginny Brockway, Lars Schultz-Nielsen, Mike Choate, Damien Brockway, Mark Derocher, Chip Getchell, Kevin Gurney, Chris Garner, Rob Richards

Longevity Awards

Steve Helme -25 years
Paul Thompson - 20 years
Jaye Wilde & Paul Begin - 15 years
Damian Brockway - 10 years
Fred Campbell, Kim Lane, Jay Pfingst & Rob Richards - 5 years

Patient Care (as recognized by unsolicited Patient Feedback)
Waterville - Peter Massey; Augusta - Gene Hassen

Peer Recognition (Voted by Delta Employees)
Waterville - Jeremy Damren; Augusta - Amy Wilson, Rob Richards

Community Service (Participation in Community Outreach)
Waterville - Jeremy Damren; Augusta - Gene Hassen

Silent Hero (Voted by Delta Employees for unrecognized contributions)
Jeremy Damren

Delta Ambulance is a not-for-profit service organization providing expert, professional paramedic care and response to citizens of Central Maine from locations in Augusta and Waterville. To learn more about our service and employees, visit http://DeltaAmbulance.org.

Left to Right: Chip Getchell, Paul Thompson, Jay Pfingst, Gene Hassen, Fred Campbell, Rob Richards, Norm Mathieu, Jeremy Damren.



Congratulations to all Staff for 1,000 Day Safety Achievement

Delta Ambulance congratulated its entire staff for reaching 1,000 days (343,291 personnelhours) without a work-loss injury.

"This is an important milestone. We attribute this to an active Safety Team and the conscientious awareness of all of our staff," said Tim Beals, Delta's Executive Director.

Along with staff education in ergonomics, spinal mechanics, and lifting and moving techniques Delta has added specialized patient moving equipment such as glide boards, stair-chairs, and electric-hydraulic patient stretchers.

"We hope for thousands more in such a difficult profession" Beals added.

Delta Ambulance is a not-for-profit paramedic ambulance service serving central Maine with professional emergency response and transfer services. Visit us on the web at www.DeltaAmbulance.org.



2007 Maine EMS AWARDS

Governor's Award

Danel Bahr, EMT-P County Ambulance Ellsworth, ME

Excellence in EMS

Cindy Rossi, EMT-I - EMD

Machias Ambulance Service

Washington County

Regional Communications Center

Lifetime Achievement Award

Mark Baker, EMT-P (25 years) Caribou Fire & Ambulance

Lois Libby, EMT-I (25 years) Machias Ambulance Service



2007 EMS Award Recipients (L-R): Gov. John Baldacci, Mark Baker, Chief Wayne Werts (Board of EMS Chairman), Marjorie Dyer, Chris Burnham (and his son), Danel Bahr, Cindy Rossi, Lois Libby, and Jean Cashman (missing from photo are James Brann and Eric Strout). (photo by Nancy P. McGinnis)

EMS Merit Award

Eric Strout, EMT-B
G & H Ambulance Service
Glenburn, ME

Christopher Burnham, EMT-P Naples Rescue Unit Marjorie Dyer, EMT-B Yarmouth Rescue Unit

James Brann, EMT-B Whitefield Rescue

Jean Cashman, LCSW Aroostook EMS CISM Team

Pediatric Trauma MANAGEMENT

MONDAY, JULY 30th

Penobscot Bay Medical Center, Rockland 4:45 pm Registration

Didactic instruction on pediatric trauma

TUESDAY, JULY 31st - THURSDAY, AUGUST 2nd PenBay Hospital, Rockland

The LifeFlight Foundation's Human Patient Simulator will be at PenBay and available for EMS providers to participate in hands-on pediatric trauma instruction. CEH credits will also be awarded for both parts of this conference.

For more information, contact

Mid Coast EMS at 785-5000

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MAINE EMS I/C NEWS

From the I/C News editor...

Greetings all! It was nice having some time off from having to do this newsletter, but it's even nicer to be back in business. I hope you all checked my web site periodically, as I tried to keep it updated whenever I heard news.

I had the opportunity to do a presentation at work the other day, un-EMS related. Because it was my first major presentation in my new job (I had to do a case study for some clients who are considering hiring my company), I knew a lot was riding on how well I prepared, both for the sake of my company's getting the account, as well as because my bosses would be taking stock of how well I did to help decide whether to use me in future situations. My EMS teaching experience proved to be invaluable. I reminded myself that if I can teach to a class of EMSers attending a refresher for the fifth time, most of whom don't even want to be there, I can certainly teach to a group of suits who all want to be there because they want to find out what my company can do for them! And once I reminded myself that I am the one who knows all about my patient, and they are the ones who want to know all about my patient, I was able to focus on simply transferring that knowledge.

I hope each of you finds that your experiences as an EMS instructor help you out in your life in general. We are very fortunate to have these great opportunities to make a difference not only in the lives of our students, but also in the lives of their patients, and when that opportunity has a positive impact in other areas of our lives, it's just frosting on the cake!

Scott Smith, who started as the MEMS Education Coordinator in September, has resigned his position. I wish him well in his future endeavors, and wish to acknowledge his enthusiastic support of this newsletter in the time he was at MEMS. The process to hire a new Training and Education Coordinator is underway.

I mentioned in the last issue of the newsletter that I had had a computer hiccup and lost my I/C News distribution list. I was able to restore it from a backup, but occasionally find an address that is no longer correct. I would really appreciate it if you have not been receiving e-mail from me if you could make it a point in the next day or so to send me an e-mail and let me know what your preferred e-mail address is for I/C correspondence and announcements. I do not give out your addresses (much to the dismay of many people who ask for them) because I realize how important e-mail privacy is. So please, just send a quick note—you don't even need to write a message if you don't want to!—to jackyv@vaniotis.com so I'll know how to reach you.

State News

MEMSRR Electronic Run Reporting

Ben Woodard, WEMT-B

MEMS Data and Preparedness Coordinator

At the recent I/C Refresher in Bangor, Scott Smith mentioned that instructors should include electronic run reporting in their EMT and Paramedic classes. Electronic run reporting is not a fad; it is a key to the future of EMS. The first two states to be 100% electronic, Minnesota and New Hampshire, use the same system that Maine is using. The webbased State Bridge, www.memsrr.org, can be accessed for practice by using the username "rescue" and password "provider" (without the quotes). Training for the tablet PC based Field Bridge can be accessed at www.imagetrend.com/ems. Please feel free to contact Ben Woodard at ben.woodard@maine.gov or at 626-3861 or for more info.



Regional News

KVEMS

Kelly Roderick; Region 3 Office Manager

New Education Chairperson

The KVEMS Executive Council unanimously approved Tiffany Stebbins, EMT-P, as the new regional Education Chairperson. Tiffany is a paramedic with Delta Ambulance, Redington Fairview EMS, and AMS Ambulance. She is a Maine licensed instructor coordinator and has been teaching basic EMT classes at KVCC for over three years. Tiffany has also taught EMS programs at the Maine Criminal Justice Academy in Vassalboro. She will serve as the regional representative to the Maine EMS Education Committee, and will be a member of the KVEMS Executive Council representing Anson-Madison-Starks Ambulance.

Welcome, Tiffany! Also, anyone interested in working on education issues here in Region 3 is invited to come to one of our monthly meetings, which are held the second Thursday of the month at 11:30 a.m. at the regional office in Winslow.

I/C Course

KVEMS is running an instructor/coordinator initial program from April 13th through May 25th. As always, each candidate for the program will have to complete student teaching prior to being given I/C credentials.

From the KV Pulse

Brian Chamberlin, BS, FF, EMT-P; KVEMS Education Coordinator From The Education Corner of the KV Pulse. Used with permission.

Many of you may not be aware that KVCC has reinstituted the Advanced Emergency Care degree program at their institution. For those interested in working towards your associate degree, please contact the admissions office at KVCC (453-5000) or call Brian at KVEMS (877-0936) for more information.

SMEMS

As many of you probably know, Liz Delano has resigned her position at Southern Maine EMS and accepted a position as Education Coordinator at United Ambulance in Lewiston. Liz joined Southern Maine EMS in 1989 after being recruited by Charlie Little, Southern Maine EMS's Medical Director at the time. In the 18 years that she has been the Education Coordinator, Liz has been instrumental in improving the quality of the licensure programs in the region, infusing principles of adult education into the EMS curriculum, and developing clinical sites. In addition to her influential role in Regional and State Education, Liz distinguished herself internationally as well. She was the lead instructor/coordinator for the Saudi/SMEMS paramedic program in the early 1990's, and has assisted in the development and instruction of the Paramedic program in Ireland.

United has gained a top-notch educator to continue the development of their training and education division, and she will be sorely missed in the Southern Maine EMS Region.

MCEMS

Ron Dupler, a Maine EMS instructor coordinator since 1993, died on March 10, 2007, at his home. In August 2005, Ron had a heart attack and went into cardiac arrest, from which he never fully recovered. He was 69 years old.

Ron's varied career included serving ten years in the United States Air Force, as well as working as an engineer, working in electronics sales, in hotel management, and in EMS. He became a basic EMT in 1989, an intermediate in 1990, and an I/C in 1993. He drove with Ace Ambulance, and was also with Seacoast Ambulance, Camden First Aid, and Sterling Ambulance Service.

In addition to teaching EMS classes, he was also an American Heart Association instructor, a board member of the Mid-Coast EMS Council, and served on their Executive Committee. Ron was inducted into the EMS Hall of Fame in November, 2006. He worked in EMS until his illness in 2005.

Ron Duper was laid to rest on Thursday, March 15, 2006, surrounded by his wife, Susan Dupler, RN, family members, friends, and by his extended EMS family. It is Ron's family's hope that people will honor his memory by donating to the Ronald L. Dupler Sr. Memorial Scholarship Fund. For more information or to make a donation, please contact Mid-Coast EMS at (207) 785-5000.

MAINE EMS I/C NEWS

Committee Briefs

Education Committee

The Education Committee meets at 9:00 a.m. on the second Wednesday of each month. Please call the MEMS office to confirm the date and time of the meeting before coming. Everyone is welcome.

Exam Committee

Jacky Vaniotis, RN, NREMT-P; Exam Committee Chairman

Much has happened with exam matters since the last I/C News update. For starters, Rick Miller was introduced at the October 17th meeting as the new Region 4 (NEEMS) representative to the Exam Committee, and Yvonne Drown was introduced at the February 20th meeting as the new Region 6 (MCEMS) representative.

This past fall, Kelly Roderick brought before the committee a letter from Mark King identifying a number of areas in which the Intermediate practical skills testing sheets were out of date since the newest protocol and AHA guidelines revisions. These included the route of administration for epinephrine, CPR changes, the lack of mention of rescue airway devices, and the starting dose of Narcan. Mark's letter became the stimulus for an extensive discussion of how best to bring all the EMT-I skills testing sheets up to date in the most expeditious way. The end result was a recommendation to the Board that Maine EMS adopt the National Registry bleeding, splinting, spinal immobilization, and assessment skill sheets at the Intermediate level. The committee also recommended specific revisions to the previous MEMS Intermediate skill sheets for cardiac care, airway management, and intravenous therapy and bolus medications. The Board was asked to make these changes effective for all Intermediate programs starting after January 1, 2007.

Also this past fall, the Maine EMS Board approved adoption of the NREMT paramedic written and practical exams as the Maine state written and practical licensure exams. Effective July 1, 2007, all paramedic candidates tested in Maine will take the NREMT computer-based test and practical exam. Any candidate who does not successfully complete the MEMS written exam prior to July 1, 2007 will need to complete both the NREMT computer-based test and NREMT practical exam. The Exam Committee hosted an open meeting with representatives from the National Registry in January, explaining in detail both their written and practical paramedic exams to help everyone understand this process.

Any instructor who wishes to see the DVD on the process for signing up for CBTs can contact his or her regional office or program director. NREMT sent several copies of these DVDs out. The information can also be found on the NR's web site, www.nremt.org. This introductory material is mostly focused on the needs of the candidates, so is worth showing during licensure courses.

The MEMS Board this fall approved a "three strikes" policy for testing: a candidate for state testing will be allowed three opportunities to complete each component of the state written/CBT and practical exam. If the candidate fails three attempts at either the written/CBT or practical components, the candidate may complete a Maine EMS approved refresher course and have three more opportunities to complete the written/CBT and practical exam components. If the candidate fails to successfully complete the state written and practical exam after six attempts at either the written or practical component, the candidate must complete an initial course-leading-to-licensure prior to being allowed another opportunity to test.

The Exam Committee recently received clarification from NREMT about Assessment Exams. (In the past, MEMS has tested EMT-Basic candidates who are 17 years old with the NREMT Assessment Exam, instead of with the regular NREMT exam. While the Registry's age of eligibility for certification is 18, MEMS had had an agreement with NREMT that they would hand-score exams of 17 year olds who, upon reaching the age of 18, could then apply to the NREMT to be awarded registration.) With computer-based testing, both 16 and 17-year-olds will take the Assessment Exam. As in the past, 16-year-olds wishing to become registered after they reach 18 years of age must retake the NREMT practical and cognitive tests in order to become registered. However, 17 year olds who complete the practical testing and the CBT Assessment Exam may apply to NREMT upon reaching their 18th birthday, and NREMT will grant registration based upon the practical exam and Assessment Exam taken with the student was 17 years of age. The Assessment Exam evaluates the students' knowledge the same as does the regular exam, so students considering taking that exam should be discouraged from believing that they will be getting an easier test.

As for looking ahead, at its first regular meeting of 2007, the Exam Committee identified all those items that it would like to consider over the next year. The group set three priorities to start the year off: EMT-Intermediate written exam update; Exam Administration Manual update; IPE data review and action. At its March meeting, the committee will begin work on these priorities by developing a strategy for dealing with the Intermediate written exam.

Please feel free to attend any meeting of the Exam Committee, which meets on the second Tuesday of each month at 9:30 a.m. As always, we recommend that you contact the MEMS office to make sure a meeting has not been canceled or rescheduled.

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Teaching Tips

Electronic Run Reporting Slides Available

Sean Hall, EMT-P, CCT; Bar Harbor Fire Department

I have updated my PowerPoint slides on electronic run reporting to reflect recent changes. I have sent a copy to Ben Woodard, and if people would like I can e-mail them a copy as well. If people want the new version they can just e-mail me at olddochall@gmail.com. The new version will say 3.6 on the first slide. Starting in June I will be more than happy to teach and promote electronic run reporting. I only ask for gas money; I can no longer do it for free thanks to the price of gas.

Incident Response

Sean Goodwin; Kennebec County Emergency Management Agency By now (as in 2006) all EMS, police and fire responders should have taken ICS/NIMS IS-700 and ICS-100. This year, some of the responders need to take ICS-200 and a few of us need to take ICS-300 and ICS-400.

If there is any good coming out of this mandate from the Feds, it is that the classes teach us how to work together at a incident and, yes, some of the classes (IS-700, ICS-100 and ICS-200) can be done online. It's a lot better to take the classes in a classroom setting, though, as one will get much more information than when taking them online. In the classroom setting, students will see where they "fit in" during an incident. ICS-300 and ICS-400 can only be done in a classroom.

For the street/operational type responder, IS-700 and ICS-100 will do for 2006, taking ICS-200 will bring you in line for 2007.

For those overseeing towns and cities and/or running operations and agencies, ICS-200 and ICS-300 are a "must."

For those who want to be on an IMAT (Incident Management Assistance Team), take IS-700, ICS-100, ICS-200, ICS-300 and ICS-400, and, if you have any time left over, throw in IS-800 and IS-703.

Our town and city leaders also need to be trained in NIMS, if they are going to be doing any planning or showing up at an incident to help. They take IS-700, ICS-100, ICS-200 and IS-800.

Without the implementation of NIMS in your town or city, you will not be able to get fire/EMS money from the federal government. No NIMS, no Fire Act funds in 2007; no NIMS, no Homeland Security funds in 2008; no NIMS, no SERC funding for Haz-Mat training funds this year.

MEMA and the counties are leading up the training for the state. Your county can set up training for you; just ask.

2006 saw a large push for IS-700 and ICS-100 and ICS-200 and some IMAT training. This year, the push is for ICS-200, ICS-300 and some ICS-400, and lots of IMAT training.

If you live or work in Kennebec County, please call our office at 623-8407 for any help or needs. The phone book will list the other county EMA office phone numbers or you can call Mike Grant at MEMA 624-4460 for your needs. For more information, you can go to the FEMA web site at www.fema.gov/emergency/nims/nims_training.

Take care, be safe!













MAINE EMS I/C NEWS

Current Research Review

Use of Dimensional Analysis to Reduce Medication Errors in EMS

By Daryl Boucher, MS, RN, CCEMT-P, Allied Health Coordinator, Northern Maine Community College

Dimensional Analysis, an old method of mathematical computation used in chemistry applications, has recently been developed for pharmacological calculations. It is extremely useful in teaching how to do medication dosage calculations to students with little experience with algebra or for those with weak math skills. Northern Maine Community College has been using this method in its Nursing and Allied Health programs, including EMS, for several years. One of the major advantages to this method is that students can use the same mathematical set-up for every calculation, and there is no need to memorize formulas. Once they learn the system, healthcare professionals can perform anything from simple metric conversions to complex drip rate calculations.

Greenfield, et al. (2005) completed a pilot study that evaluated whether using Dimensional Analysis as a method of math calculation could reduce calculation errors. Students' scores using the Dimensional Analysis method were compared with the traditional teaching approach of formula memorization; the results revealed that the Dimensional Analysis group scored with greater accuracy and made fewer calculation errors than did the traditional math group. Students in the DA group excelled at converting units for oral, parenteral, intravenous, and body weight-based medication calculations. Though this study measured the ability to come up with correct answers on a written exam with simulated scenarios, the results are easily transferable to real patient situations.

The implications of this study are important. The national agenda continues to focus on preventable medication errors. In fact, a recent commentary written by Zachary Meisel identified ambulances as "one of the most dangerous places for patients to be." Meisel's work cites various calculation errors by paramedics that have led to patient injury or death in the pre-hospital arena. As educators and professionals, we know that it is important to assure that pre-hospital providers are able to perform to established standards, and those standards include safe medication administration. As a method for dosage calculation, Dimensional Analysis is emerging as a safer, easier, and more reliable approach. An approach which hopefully will lead to fewer errors and better patient outcomes than traditional methods.

Though it is impossible to present the intricacies of the entire system in a short article, I will attempt to present a few key points. First, the process can be learned using a programmed study text by Curren, called Dimensional Analysis for Meds. If you have struggled to do or teach pharmacological calculations, I would encourage you to attempt using this text. The process allows medical personnel to convert measurement weights (i.e. milligrams to grams), convert from one system to another (i.e. apothecary to household to metric (i.e. pounds to kilograms), or to do complex mathematical computations using only one equation (i.e. such as would be required for a lidocaine drip). Once you have learned a few basic rules, you will have established the foundation to complete even more complex problems. (Students of this system must still commit measurement units to memory.)

In traditional ratio and proportion conversions and calculations, students were required to divide or move decimal points before beginning the actual calculation. Additionally, they had to learn multiple formulas depending on the situations (i.e. conversions, IV drips, medication drips, etc.) For example, if the student is required to administer 30 mg of a medication, and the medication is available as 2 grams in 10 ml, in the traditional formula-based approach he would follow these steps:

Dose ordered x vehicle = amount to give

- 1. Convert mg to grams, either by moving the decimal point (which has a high risk of error), or by calculating: if 1g = 1000mg, then 2 = 2000mg
- 2. Next, he would place the numbers into the formula $(D/H \times V) =$ amount to give:

 $\frac{30 \text{ mg}}{2000 \text{ mg}} \times 10 \text{ mL} = 0.15 \text{ mL}$

Or, he could choose to cross-multiply (which requires some level of algebraic knowledge) to be able to solve for "x." However, regardless of the approach he uses, for every additional step in the calculation process, he increases the risk of error. With the above system, needing two to three equations is not uncommon. The more complex the problem, the more calculations are required and therefore the greater the risk of error.

In Dimensional Analysis, the same calculation is done in one combined equation:

? mL x
$$10 \text{ mL}$$
 x 1 gm x 30 mg
= 300 ml = 0.15 mL

To calculate the result, you multiply all the numerators (top), and multiply all the denominators (bottom). Then you divide the top by the bottom of the resulting fraction to yield the answer. There are a couple of safety checks to the system to assure there are no errors:

- Note in the original equation how the labels from the denominator match up with the subsequent numerator (i.e. grams matches grams). This allows you to cancel the labels, and you are left with the desired measurement unit, in this case, mL, that is not cancelled.
- 2. The known conversion factor is part of the equation (1g = 1000mg). This helps assure there are no errors in the calculation.

Here are a couple of dimensional analysis problems. I would encourage you to solve them using your current method, and then look at the example for DA that I provide. Then, determine for yourself which method is easier to perform, is easier to teach, and most importantly has less chance for error.

 a. 12 microgram per minute drip of a medication is ordered. The medication is available in an 8 mg/250 mL solution. Calculate the drip rate using a microdrip set (60 gtts/ml).

DA set up:

$$\frac{? \text{ gtts}}{\text{min}} = \frac{60 \text{ gtts}}{1 \text{ mL}} \times \frac{250 \text{ mL}}{8 \text{ mg}} \times \frac{1 \text{ mg}}{1000 \text{ mcg}}$$

$$\times \frac{12 \text{ mcg}}{1 \text{ min}} = 22.5 \text{ gtts}$$

b. An IV mediation with a volume of 60 milliliters is to infuse at 45 drops per minute. Using a microdrip set, calculate the infusion time.

DA set up:

? min =
$$\frac{1 \text{ min}}{45 \text{ gtts}}$$
 x $\frac{60 \text{ gtts}}{1 \text{ mL}}$ x $60 \text{ mL} = 80 \text{ min}$

c. A pill contains 6 milligrams. How many micrograms is this?

DA set up:

? mcg=
$$\frac{1000 \text{ mcg}}{1 \text{ mg}}$$
 x 6 mg = 6,000 mcg

d. How many kilograms does a 21 pound child weigh?

DA set up:

? kg=
$$\frac{1 \text{ kg}}{2.2 \text{ lbs}}$$
 x 21 lbs = 9.5 kg

Notice that the setup of all of these problems is the same—there no need to learn a new formula as the situation changes, as long as you know the standard equivalents. Also note that by canceling labels (i.e. pounds on top and bottom), you are left with the measurement you looking for.

One of the neat things with the Dimensional Analysis process is that it is relatively easy for those already experienced with calculations to relearn. But for students who have little math experience, it is also easy to teach and easy to learn. Additionally, once learned, even if you have not done a calculation for a while, it is easy to remember. Though this method clearly will not eliminate all calculation errors, it certainly has been shown to help.

If you would like more information about the Dimensional Analysis method for drug calculation or would like to schedule a training session for your staff, please contact Daryl Boucher via e-mail at dboucher@nmcc.edu.

Resources:

Curren, Anna M. (2006). Dimensional Analysis for Meds, 3/e. New York: Delmar Thomas, 1998. On line link: www.delmarlearning.com/

Meisel, Zachary. (2005). "Ding-a-Ling-a-Ling; Ambulances Can Be Dangerous Places." Slate 8 November 2005. 20 March, 2007

www.slate.com/toolbar.aspx?action=print&id=2129684

Greenfield, S. Whelen, B. & Cohn, E.. "Use of Dimensional Analysis to Reduce Medication Errors." Journal of Nursing Education 45.2 (2006): 91-94.

MAINE EMS I/C NEWS

JACKY VANIOTIS, EDITOR

In My Opinion

Mark A. King, M.A., EMT-P; Winthrop Ambulance and Northeast Mobile Health Service

I am passionate about teaching EMS and about my students. I recently taught a First Responder class at the fire station in Mount Vernon. I had only seven students, but I believe that this class may represent the "ideal" model for Maine EMS.

I'll take a moment to tell you why: Too often we turn out capable EMTs who, because they live in remote areas with very few calls, miss out on opportunities to work with a transporting service, and, as a result, become stagnant; watching their skills slowly decline until their comfort level precludes them from going on calls. Eventually, they lose interest and let their licenses lapse—a true loss to our EMS system.

In my case, seven Mt. Vernon citizens were to be licensed to provide patient stabilization and supportive care until Winthrop Ambulance arrives to complete the transport for them. I stressed to them on numerous occasions that, while it often takes 15 minutes for Winthrop to get to the scene, it takes only a couple of minutes for these FRs to arrive. In the time span between their arrival and Winthrop's, negative outcomes can be changed with a few basic interventions that they will have to

offer. My favorite example: a cardiac patient experiencing a serious MI can benefit immensely from a First Responder providing oxygen (to help reduce the extent of the MI) and kind words to help lower anxiety. Without First Responders, our rural EMS network would surely unfold. At this level, skills are easy to master and hard to forget. Additionally, Winthrop Ambulance has a very strong relationship with Mt. Vernon Rescue, and many of our fine paramedics were once First Responders with Mt. Vernon Rescue. Rescue members are invited to trainings and encouraged to do "ride along" time with the duty crews. This allows them to see what happens to their patient once the ambulance doors close. This has been an invaluable experience for both the rescue folks and the ambulance staff—as we can definitely continue to learn from each other!!

So in short... I believe that our educational push for the future should include more emphasis on the small, rural communities and the First Responder level. My experience has shown that those who excel at the First Responder level routinely move on to become EMTs and many even medics!!

NREMT News

There were a couple of interesting notes in the spring 2007 issue of The Registry, the NREMT's newsletter, one on an examination option for recertification, one on the use of mannequins for the practical exam, and one on cheating.

In November 2006 the Board of the NREMT approved allowing EMT-Basics, Intermediates, and Paramedics to take the National Registry's computer-based test in lieu of completing a combination of refresher course and continuing education hours in order to recertify. Only one attempt at passing the exam is allowed, and candidates who fail the examination will be required to complete all refresher and continuing education requirements in order to recertify. EMTs whose certification expires in 2008 may challenge

the examination beginning October 1, 2007. More information is available at the NREMT web site, NREMT.org.

The second item of interest in the Registry's newsletter is that the NREMT is going to be convening a group to investigate the use of state-of-the-art simulation mannequins, which can be programmed with any number of illnesses, injuries, or other presentations, in its practical exam. The Registry believes that the use of these mannequins "can be extremely useful in standardizing the practical exam, which would lead to a more consistent and fair exam."

The Registry newsletter also recommends an article on cheating, which is available on its web site at www.NREMT.org/downloads/educator-update-April-2006.pdf.

Last Words

Please submit any materials you would like to have published in the next issue of the I/C News by August 10, for publication in the Journal of Maine EMS at the beginning of October.

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Maine EPIC

EMERGENCY PHYSICIANS INTERIM COMMUNIQUE

JOHN SAUCIER, MD, EDITOR | MAINE MEDICAL CENTER

Primary Stroke Center status was afforded Maine Medical Center in March of this year. Final approval will be pending a four-month review of some stroke protocol changes. The JAHCO process was preceded by years of work throughout Maine Health, Maine Medical Center and New England Rehab. Although it is good to be awarded the "merit badge", more significantly the coordination required between the various clinical arenas involved in stroke care has resulted in a marked improvement in stroke care in general. The ability to provide thrombolysis to appropriate patients who fall within the allotted three hour window can result in lessened deficits for a minority of patients. Most patients, however, will not receive the clot buster but will still benefit from services they receive from a coordinated stroke program. Steve Diaz, MD (State EMS medical director) and others are now spearheading an effort aimed at increasing EMS provider awareness of the urgency of early stroke diagnosis and management. As more stroke centers emerge in the state, a model similar to that of AMI is predicted. This might include tPa given in a nearest appropriate Emergency Department under the guidance of a neurologist and radiologist from a regional stroke center with resultant transfer to such a center for continuing and comprehensive care.

The 25th Annual Sugarloaf Winter Symposium was held at the end of February to an enthusiastic, if decidedly sparser, group of participants from around the state and New England. This was a transitional year as John Burton, MD who had directed the program over the last sev-

eral years, left the state to direct the residency at Albany Medical Center in New York. John Saucier, MD and Mike Baumann shared that responsibility this year and are looking forward to a more robust conference for 2008, directed by one of the younger members of MMC's faculty, Carl Germann, MD. Stay tuned for early notification for 2008 and an exciting educational event.

The Colby Emergency Medicine Update will be held on the Waterville campus July 24-27, 2007. Mike Gibbs, MD is finalizing the agenda for the conference as of this writing but will include the 2007 LLSA review, a topic day on medical legal issues and one on neuro-medical advances. Check the Colby College web site, under summer programs for more up to date information. (http://www.colby.edu/spec.prog/cme/emergency_medicine/index.shtml)

Have you ever wondered what to do when in the fall, anxious parents present their smiling toddler and a small chewed piece of mystery material and pronounce that their cherub has just eaten a deadly toadstool? Well even if you haven't we have an interesting course this fall for you. The first annual Toxic Mushroom and Edible Look-alikes course for medical providers will be offered at the Humboldt Institute in Steuben , Maine September 13-15th, 2007. Codirected by Laurie Leonard, MD (a retired orthopedist and respected mycologist, John Saucier, MD, and Tamas Peredy (now medical director of the Northern New England Poison Control Center) this 17 Category 1 credit course will include a combination of didactics with extensive field and lab work on mushroom identification and toxicity management in a wonderful setting in Downeast Maine. See www.eaglehill.us for more information or email me at saucij@mmc.org .

THE RESIDENTS CORNER

Anna Waterbrook, MD, Chief Resident, MMC EM Residency program: We are very pleased to announce our 2007 Intern Class at Maine Medical Center. We have once again attracted an outstanding group of interns from all over the country. Please join us in welcoming them all to Maine, and the field of emergency medicine!

Daniel Britton: Dan comes to the Department of Emergency Medicine having completed a year of Internal Medicine residency at MMC. At the age of 16, Dan became a professional soccer player, first in Australia, then moving up to England's premier league. Having crossed professional athlete off of his "to do" list, Dan returned to Australia for his medical education at the University of Queensland in Australia. Dan's wife Megan is an Intern in the Department of Family Medicine here at MMC. They have a daughter named Olivia and have just added a son, Matthew, to their family.

Thomas Cochran: Tom comes to MMC from the University Of Rochester School Of Medicine. During medical school, Tom was selected to participate in a neurology teaching fellowship in Krakow, Poland. Ad-

ditionally, Tom was a volunteer on the Mississippi gulf coast immediately following hurricane Katrina. Besides joining our growing list of triatheletes, Tom is an accomplished skier, having been a three-time high school alpine state champion. Tom will be joining our department along with Allie Mottl (see below).

Thomas Ewing: Tom comes to MMC from Oregon Health Sciences School of Medicine in the "other" Portland. Prior to medical school, Tom served in the U.S. Navy as a naval aviator (i.e. he landed jets on aircraft carriers...and then taught others how to do it). He rose to the rank of Lieutenant Commander during his 11-year career in the Navy. Tom is an avid runner, loves to cook, and is headed East with his wife, Danielle, who is an accomplished hospital administrator.

William "Doug" Gregorie: Doug comes north to MMC from the University Of South Carolina School Of Medicine. During medical school, Doug has volunteered on medical missions in Haiti and published in the field of nephrology. Tom was the director of rock climbing for the Sewanee Outing Program, and was captain of the men's varsity tennis team while an under-

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THE RESIDENTS CORNER

graduate (where he was also named Division III rookie of the year for 1998). Finally, for the runners, Doug has set a new high-water mark by completing an ultra marathon. Doug will be moving North with his wife and child.

Sarah "Sadie" Johnstone: Sadie comes to us from Georgetown University School of Medicine. Sadie grew up in China, and speaks Mandarin Chinese. Following her undergraduate education, Sadie was director of admissions and development at the International School in Perth, Australia. In 2005, Sadie and her husband founded the non-profit organization "Beyond the Walls" to expose city students to experiences beyond their local communities. Sadie is moving to Maine with her husband John, who currently is a 6th grade teacher.

Eric Moore: Eric joins the residency graduating from the Medical College of Wisconsin. Eric has had extensive volunteer experiences during medical school, where he worked and coordinated volunteer efforts at the Greater Milwaukee Free Clinic. Eric has also participated in medical research regarding immigrant health issues in Mexico. Also during medical school, Eric organized and taught a medical Spanish class, as well as served as a Spanish language interpreter at a free clinic.

Alexis Mottl: Allie comes to MMC from the University Of Rochester School Of Medicine. While an undergraduate, Allie was a disc jockey at WHRW in Binghamton. During medical school, Allie received numerous awards (American Society of Hematology and an Office of Medical Education Research award). Allie has had research experience at the Dana-Farber Cancer Institute and has published in the field of Hodgkins Lymphoma. Allie's interests include running and kayaking. Allie will be joining our department along with Tom Cochran (see above).

Hamilton Wells: Hamilton comes to MMC from Case Western Reserve University School of Medicine. Hamilton received his undergraduate degree from Illinois State University where he was a 4-year varsity letter winner and captain of the football team (the Redbirds), where he played linebacker. During medical school, Hamilton has participated in research regarding ACL injuries in athletes and presented his results at a national meeting. Hamilton has significant experience with travel in South America, and is an avid outdoorsman. Hamilton is moving to Maine with his wife.

Aroostook Region News

Congratulations!!!

At this time Aroostook EMS would like to announce the appointment of the new CISM Team Coordinator, Liane Norsworthy. Liane is affiliated with Crown Ambulance in Presque Isle and has been working diligently along side past CISM Coordinator Steve Corbin learning the ins and outs. We'd wish you good luck, Liane, but you're not going to need it. We know you're going to do a fabulous job!

Run Reporting Workshop

The Aroostook Regional office, in conjunction with Maine Emergency Medical Services and NMCC, hosted a one day Electronic Run Reporting program in March. The topic for was the "MEMSRR/ImageTrend Electronic Run Reporting System, designed to train individuals to instruct electronic run reporting training for their respective departments or services. In addition to this training, each Regional Service has the necessary information and resources needed to consider the transition to electronic run report submission to Maine EMS. The guest presenter was Ben Woodard, Maine EMS/Augusta. Continuing Education credits were awarded.

Stepping Up to MCI Training

The Regional office, in conjuction with Maine Emergency Medical Services, hosted a one day "train the trainer" program in April. The topic for this event was "Stepping up to MCI", designed to train individuals to instruct Mass Casualty Incident training for their respective departments or services. In addition to this training, each Region V Service received new Mettags for each Ambulance unit, which were distributed the day of the event. The guest presenter was JoAnn Lebrun, Regional Coordinator for Region 2, Tri-County EMS. Continuing Education credits were awarded.

Avian Influenza Public Information Session

The City of Caribou, in cooperation with Aroostook Region V Emergency Medical Services, conducted a public information session to discuss Avian Influenza in April at the City Council Chambers.

The presentation featured Patti Carson, Infection Control Nurse from Cary Medical Center who discussed the signs and symptoms of seasonal and pandemic strains of influenza.

In addition, Kathy Knight, RN from the Northeast Maine Regional Resource Center in Brewer, was on hand to discuss what preparation plans and activities have been developed to prepare the responders in the event of a pandemic or other large scale disaster that could effect our Region.

Following the presentations, there was a question and answer period with a panel consisting of:

Patti Carson, Infection Control Nurse, Cary Medical Center Steve Corbin, Regional Coordinator, Aroostook Region V EMS Dean Grivois, Project Director, The Power of Prevention, Healthy Maine Partnership

Kathy Knight RN, Director, Northeast Maine Regional Resource Center

Ken Murchison, City Councilor, City of Caribou Sherry Belanger, Caribou Citizens Emergency Response Team

The event was also broadcast live and re-aired at subsequent intervals on the Time Warner Cable Local Access Channel.

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Kennebec Valley News

KVEMS Says Goodbye

Lisa Day, Clerical Assistant at KVEMSC, left her position here at KVEMSC on May 4th. She came to us four and a half years ago at a time when the workload at KVEMS was growing quite rapidly. While here, her duties were to maintain the financial records, oversee the continuing education records and staffing the Council meetings. Lisa is a licensed EMT-Intermediate with Belgrade Rescue and also serves as that department's Rescue Chief. We invite you to join us in wishing her well and thanking her for her dedicated work to the region.

KV EMS & KVCC To Host Fall 2007 EMT-Intermediate Program

Maine EMS Licensed EMT-Basics who are interested in advancing their EMS license level can apply for the fall 2007 EMT-I Program that will be held at KVCC starting in August.

The class will be held on Tuesday and Thursday evenings from 6-10 pm and the cost will be approximately \$1800. Those interested in taking the course should start gathering the support materials need, such as copy of immunizations, proof of health insurance and proof of Maine EMS License. For more information candidates can contact KVCC Admissions or KVEMSC for more details.

KVEMSC Holds Annual Meeting

KVEMSC will hold its Annual Meeting and Elections June 21, 2007. This annual tradition of holding a dinner meeting has allowed us an opportunity to invite those service chiefs and other regional members to attend a council meeting in the evening. Meetings are generally held during the work week and some representatives cannot attend because of a commitment to their "real job". The dinner is in a relaxed atmosphere and allows each of many a chance to network, get caught up and be heard. The results of this year's election were not available at the time this went to press.

Wm. Thomas Hyde Memorial Award

The 4th annual Wm. Thomas Hyde Memorial Award will be presented on June 21st at the Annual meeting. This award is presented to the EMS, Fire, Police or Dispatch provider from Region 3 who best represents the characteristic of Tom. Tom was a well respected and dedicated EMS Provider, Firefighter and educator who knew how to balance both this commitment to his family and to his EMS career. Anyone from Region 3 wishing to submit a nomination can do so by contacting a member of the EMS staff at KVEMS.

JUĹY 2007

MAINE EMS TEAM LEADERS

Ever wondered who to call when you have a question, complaint, concern or compliment about your EMS system? Listed below are the members of the Maine EMS Board, Maine EMS Staff, and the Regional Coordinators and Medical Directors. Each and every EMS team member in Maine is encouraged to get involved with how your system is run. So get involved—give us a call!

Maine EMS Board Members

Southern Maine EMS Rep	Ron Jones, EMT-P	23 Sterling Drive, Westbrook, ME 04092	TEL: 854-0654
Kennebec Valley EMS Rep	Tim Beals, EMT-P	PO Box 747, Waterville, ME 04903	TEL: 872-4000
Aroostook EMS Rep	James McKenney, EMT-P	229 State Street, Presque Isle, ME 04769	TEL: 768-4388
Tri-County EMS Rep	Rebecca Chagrasulis, MD	PO Box 120, Casco, ME 04015	TEL: 743-5933
Northeastern EMS Rep	Paul Knowlton, EMT-P	274 Pearl Street, Bangor, ME 04401	TEL: 941-5100
Mid-Coast EMS Rep	Steven E. Leach, EMT-P	PO Box 894, Union, ME 04862	TEL: 785-2260
Physician Rep	Peter DiPietrantonio, DO	4 Picnic Hill Road, Freeport, ME 04032	TEL: 373-2220
Nurse Rep	Bill Montejo, RN, EMT-P	363 River Road, Bowdoinham, ME 04008	TEL: 666-3093
First Responder Service	Richard Doughty, EMT-P	4153 Union Street, Levant, ME 04456	TEL: 941-5900
For Profit Service	Joseph Conley, EMT-P	11 Deer Hill Avenue, Standish, ME 04084	TEL: 642-5854
Not For Profit Service	Carol Pillsbury, EMT-P	PO Box 200, West Farmington, ME 04992	TEL: 778-6951
Attorney Representative	Alan Azzara, Esq., EMT-P	83 Ridge View Lane, Westport, ME 04578	TEL: 882-8435
State Medical Control Director	Steven E. Diaz, MD	Maine EMS, 152 State House Station, Augusta, ME 04333	
Hospital Rep	Penelope Lovejoy, RN	Penobscot Valley Hospital, Transalpine Road, Lincoln, ME 04457	TEL: 794-3321
Fire Services Rep	Wayne Werts, EMT-P, Chief	Auburn Fire Department, 550 Minot Avenue, Auburn, ME 04210	TEL: 783-6931
Fire Chief Rep	Roy Woods, Chief	Caribou Fire Department	
Public Rep	Robert Ashby	427 Memorial Drive, Winthrop, ME 04364	TEL: 377-5923
Public Rep	Oden F. Cassidy	RR 2, Box 960, Houlton, ME 04732	TEL: 532-3941

Maine EMS State Office Staff Regional Coordinators and Medical Directors

	nog.		
152 State House Station, Augusta, ME 04333-0152 TEL: 626-3860 FAX: 287-6251 maine.ems@maine.gov	REGION 1	Donnell Carroll, Southern Maine EMS Council 496 Ocean Street, South Portland, ME 04106 TEL: 741-2790 FAX: 741-2158 smems@smems.c	Dr. Elliot Smith, Medical Director
www.maine.gov/dps/ems	REGION 2	Joanne LeBrun, Tri-County EMS Council	Dr. Kevin Kendall, Medical Director
Jay Bradshaw, EMT-P Director		300 Main Street, Lewiston, ME 04240 TEL: 795-2880 FAX: 753-7280 info@tricountyems.org	
jay.bradshaw@maine.gov Scott A. Smith, RN, CEN, EMT-P Training and Education Coordinator	REGION 3	Rick Petrie, EMT-P, KVEMS Council 71 Halifax Street, Winslow, ME 04901 TEL: 877-0936 FAX: 872-2753 office@kvems.org	Dr. David McKelway, Medical Director
scott.a.smith@maine.gov Drexell R. White, EMT-P EMD Coordinator drexell.r.white@maine.gov	REGION 4	Rick Petrie, EMT-P, Northeastern Maine EMS EMCC, 354 Hogan Road, Bangor, ME 04401 TEL: 974-4880 FAX: 974-4879 neems@emcc.or	Dr. Jonathon Busko, Acting Medical Director
Dawn Kinney, EMT-P Licensing Agent dawn.l.kinney@maine.gov	REGION 5	Steve Corbin, Aroostook Maine EMS 22-A Birdseye Avenue, Caribou, ME 04736 TEL: 492-1624 FAX: 492-0342 aems@mfx.net	Dr. Jay Reynolds, Medical Director
Ben Woodard, EMT EMS Data and Preparedness Coordinator ben.woodard@maine.gov Karen Cutler Administrative Assistant	REGION 6	Bill Zito, Mid-Coast EMS Thompson Community Center Routes 131 and 17, PO Box 610, Union, ME 04862 TEL: 785-5000 FAX: 785-5002 office@midcoaste	
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